The US Oncology Network

February 7, 2017

Insurance and Real Estate Committee
Legislative Office Building, Room 2800
Hartford, CT 06106

RE: Senate Bill 23, an act Requiring Site-Neutral Payments for Health Care Services

Dear Senator Larson, Senator Kelly, and Representative Scanlon:

On behalf of The US Oncology Network, we submit these comments in support of SB 23, an act Requiring Site-Neutral Payments for Health Care Services.

The US Oncology Network (The Network) is one of the nation's largest networks of integrated, community-based oncology practices dedicated to advancing high-quality, evidence-based cancer care. A physician-led organization, The Network unites like-minded physicians and clinicians around a common vision of improving patient outcomes and quality of life. The Network is committed to strengthening patient access to integrated care in local communities across the nation, including collaboration with a variety of payers and providers.

Improving the quality and efficiency of healthcare in order to control costs has been an ongoing priority for policy makers, employers, payers, patients, and providers alike. Efforts to improve patient safety and outcomes, while tying payments to quality instead of quantity, have resulted in seismic shifts in the delivery of healthcare over recent years. This is true in oncology as well.

Yet amid these major changes and cost-cutting improvements, we still see examples of questionable and costly policies undercutting the progress being made elsewhere. Both Medicare and commercial payer payment policies are sometimes misaligned in ways that create an unlevel playing field on which independent physicians must compete with ever-larger hospital systems.

A December 2015 study[1] showed that hospitals with fewer competitors have substantially higher prices, beyond those accounted for by cost or quality differences. Hospitals that have monopolized their markets leverage prices 15% higher than those with 4+ competitors. The study also showed that hospitals with only one competitor have prices over 6% higher, and those with two competitors have prices almost 5 % higher. Working with cancer care providers, we have seen the higher rates for oncology services that hospitals command. The ongoing payment disparities between community cancer care and the same care provided in hospital outpatient departments (HOPDs) fuels the trend of hospitals acquiring community oncology practices, which has only accelerated in recent years. According to the Community Oncology Alliance's 2016 Community Oncology Practice Impact Report[2], the number of practice closures is increasing, with a 172% increase in practices that were acquired by hospitals (or with a hospital agreement).

[1] http://www.cmu.edu/news/stories/archives/2015/december/hospital-prices-vary.html
[2] https://www.communityoncology.org/wp-content/uploads/2016/09/PracticeImpactReport-2016-Report.pdf

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When the specific service is not dependent on the hospital facility's associated technologies, and in the absence of any evidence-based rationale, paying more for a service in the hospital is wasteful, costly, and endangers patient access and choice.

A decade ago, nearly 90% of America's cancer patients had many options for care in the community, but changes in reimbursements have made the previous landscape almost unrecognizable. Today, barely half of patients receive cancer care in these centers, while HOPDs saw a 150% increase in patient volume in just 6 years.[3]

For many community cancer centers, keeping the doors open means making the difficult decision to consolidate with hospitals or hospital systems. Although this allows an individual practice to survive, these consolidations increase costs overall, ultimately affecting patients by increasing out-of-pocket expenses, premiums, and limiting patient choice. A 2014 study of the medical records of 4.5 million patients published in The Journal of the American Medical Association (*JAMA)* concluded that expenditures per patient were 10.3% higher for physician groups owned by hospitals than for independent practices, and expenditures were 19.8% higher for physician groups owned by multihospital systems.[4]

A 2015 study by the IMS Institute also concluded that Americans are paying higher prices for cancer care because of acquisitions. In the report, reimbursement levels for drug administration costs in hospital outpatient facilities average 189% higher than physician office reimbursement costs for commercially insured patients under the age of 65 years. In 2014, Medicare paid HOPDs twice as much for the same drug administration service.[5] The pain in the pocketbook doesn't end there: Patient co-payments are approximately 10% higher in the HOPD, equaling more than $650 in additional costs per year for each Medicare beneficiary fighting cancer. Additionally, the average out-of-pocket patient cost for commonly used cancer drugs is $134 more per dose if received in the outpatient hospital setting. [6]

The US healthcare system today is unquestionably complex, with a great many variables affecting the cost of care. However, some problems are easier to fix than others, and this one has a common sense solution: to have policy makers help neutralize payments across sites of service and ensure payments are equivalent for the same services, regardless of where it is performed.

President Obama and Congress came together in late 2015 to include prospective site neutral payment policy in the Bipartisan Budget Act of 2015, and it is our hope that the momentum from support for similar changes in federal policy will carry over in Connecticut, as it did last year in Vermont, with the passage of SB 245, which mandated site neutral payments for the state's Medicaid program, and a study of the feasibility of extending the same payment policy requirements to commercial insurers. The AARP supports equalizing payments for physician services between

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[3] Results of analyses for chemotherapy administration utilization and chemotherapy drug utilization, 2005-2011, for Medicare fee-for-service beneficiaries. Community Oncology Alliance website. http://www.communityoncology.org/UserFiles/Moran_Site_Shift_Study_P1.pdf. Published May 2013.

[4] Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *JAMA*. 2014;312(16):1663-1669.

[5] Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/global-oncology-trend-report-2014

[6] IMS Institute, "Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report," May 2014

hospital outpatient and office settings, as does the Alliance for Site Neutral Payment Reform (www.siteneutral.org). This policy will save billions for seniors and taxpayers, and Connecticut can take a national leadership position on the policy at a state level.

Site neutrality is a critical step in the journey toward better healthcare for all Americans and a healthy future for the affordability of healthcare nationally. As such, we encourage you to support SB 23, and consider the legislative text we offer below, for your consideration in drafting the bill.

Sincerely,

Nathan Cook
Senior Manager, Government & Community Relations
The US Oncology Network

"(a) Each health insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity that contracts with health care providers to provide health care services to its insureds or enrollees, shall include in each such contract that is entered into, renewed or amended on or after October 1, 2017, site-neutral reimbursement policies as recommended by the Medicare Payment Advisory Commission's June 2013, Report to the Congress: Medicare and the Health Care Delivery System, as updated from time to time. Such reimbursement policies shall, at a minimum, (1) require reimbursement that is the same for all health care providers regardless of where the services are performed for the following: (A) Evaluation and management visits; (B) services classified by said commission as Group 1 ambulatory payment classification in said report; and (C) ambulatory surgical procedures and services identified by said commission as appropriate for equal reimbursement, and (2) limit reimbursement differentials to only the amount necessary for the actual cost of packaging ancillary services for services classified by said commission as Group 2 ambulatory payment classification in said report.

(b) Each contract under subsection (a) of this section shall include a conspicuous statement that the contract complies with site-neutral reimbursement policies as required by law.

(c) The provisions of this section shall not be construed to: (1) require an entity under subsection (a) to contract with any health care provider willing to abide by the terms and conditions for participation established by the carrier; or (2) prevent an entity under subsection (a) from establishing varying reimbursement rates between health care providers based on evidence-based quality or performance measures."